Present on Admission

Accurate reporting to ensure appropriate reimbursement

WHITE PAPER

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In an effort to improve quality of care, patient safety, and the accuracy of data collection and to provide appropriate reimbursement for services provided, Medicare and other payers now require healthcare providers to monitor patients for conditions that are present on admission (POA) per the Deficit Reduction Act of 2005. These are conditions that are present when the inpatient order is written rather than ones that developed some time after admission to the hospital.

The goal is to identify conditions caused by inadequate attention to patient care needs and safety.

Only acute inpatient hospital admissions are subject to POA reporting. The following types of healthcare organizations are exempt:

- Critical access hospitals
- Maryland waiver hospitals
- Long-term care hospitals
- Cancer hospitals
- Children's inpatient facilities

All other inpatient hospitals must now submit claims with a POA indicator assigned to the principal and additional (or secondary) diagnosis codes. However, some types of codes are generally exempt, including late effect, personal history, status post, body mass index, and most (but not all) E codes.

POA indicator reporting

The POA indicators are:

- **Y—Yes.** Present at the time of inpatient admission.
- **N—No.** Not present at the time of inpatient admission.
- **U—Unknown.** Documentation is insufficient to determine whether the condition is present at the time of inpatient admission. (Use this indicator infrequently. Query the physician to help determine if another indicator would be a better choice.)
- **W—Clinically undetermined.** The provider is unable to clinically determine whether the condition was present at the time of inpatient admission.
- **1—Unreported/not used.** Exempt from POA reporting. (*The ICD-9-CM Guidelines for Coding and Reporting* contain a list of exempt diagnosis codes in Appendix 1.)

FEATURES

Report the POA indicator in the eighth digit of field locator (FL) 67 on paper claims (i.e., UB-04). For electronic claims (i.e., 8371), list the indicators in sequence starting after "POA," and end the string with a "Z." For example, for a claim with a "Yes" principal diagnosis, "Yes" for the first additional diagnosis, "No" for the second additional diagnosis and "Exempt" for the third, report POAYYN1Z.

Note that CMS considers a condition POA when:

- It is present at the time of an inpatient admission
- It is chronic, currently under treatment, and appropriately documented as such
- It develops during an outpatient encounter prior to inpatient admission (e.g., when in the emergency room, observation, during an outpatient surgery, or diagnostic visit)

Tips for handling POA assignment

The POA indicator a coder chooses may affect the level of payment a facility receives, but it carries other implications as well. POA indicators may, over time, assist in the collection of patient safety measures. However, data quality depends on coders' knowledge of how conditions progress and how to glean POA information from the medical record.

Coders must question inconsistent, unclear, vague, missing, or conflicting documentation.

Having complete documentation is critical for accurate POA reporting. Physician documentation must support whether each condition is POA. Coders must question inconsistent, unclear, vague, missing, or conflicting documentation. According to CMS, any "provider" involved in the care and treatment of a patient can be used as a source for POA assignment, but the *ICD-9-CM Official Coding Guidelines* for POAs specify that in this context "provider" means a physician or qualified healthcare practitioner responsible for establishing a patient's diagnosis.

Consider the following tips to help coders assign the correct indicator:

- **Know where to look in the medical record.** Certain areas of the patient's record will most likely provide important clues to the coder. The best places to find POA information are emergency department notes, records from the outpatient department or observation area, the history and physical, the initial physician progress notes, and physician admit orders. Check these areas first before beginning to review the patient's entire medical history.
- **Understand chronic conditions and combination codes.** POA guidelines state that when any part of a combination code was not POA, the POA assigned is an "N." For example, you would report code 531.00 for an acute gastric ulcer with hemorrhage. If the hemorrhage did not occur until after admission, the code would be assigned a POA of "N." For situations where all components of the combination code were POA, it would be assigned a "Y." Consider the following example:

- A patient experiences a diabetic coma as a secondary diagnosis several days after admission to the hospital for congestive heart failure. Diabetes is a chronic condition, which leads one to believe coders should assign a POA of "Y" based on the chronic conditions POA guideline. But, the diabetic coma code (code 250.3x) is a combination code identifying the condition (diabetes) and the complication associated (coma). Since the coma was not POA, the coder should assign code 250.3x with a POA of "N" based on the POA guidelines.
- **Avoid U and W indicators.** Although attaching a U or W indicator to a condition may seem to save time, frequent use may cause problems. Although these indicators may seem like an easy out rather than conducting additional research to determine whether the condition was POA, failing to attach a Y or N indicator may result in unnecessary claims denials.
- **Know when a physician query is appropriate.** When a coder is unsure whether a condition requires a POA indicator, he or she should seek the guidance of a more experienced coder or conduct a physician query. Nurses may also provide critical information to help coders determine whether further investigation of a POA status is necessary. Coders may not use nurses' notes when determining whether a condition was POA, but these notes can provide useful clues to help the coder determine whether a physician query is warranted. For instance, a nurse may document a pressure ulcer several days before the physician mentions it in the patient's record.

Nurses may also provide critical information to help coders determine whether further investigation of a POA status is necessary.

- **Understand how to handle pressure ulcers.** Coders may report pressure ulcer stages based on documentation from nonprovider clinicians (e.g., nurses and physical therapists), according to *Coding Clinic,* 4th quarter, 2008. However, documentation of the pressure ulcer site must come from a provider (e.g., physician). According to the *ICD-9-CM Official Guidelines for Coding and Reporting,* coders must assign a code only for the highest stage of an ulcer during an admission. Coders should then report the "Y" indicator for the highest stage pressure ulcer.
- **Consider newborns admitted at birth.** Newborns are "admitted" after birth. Any condition present during delivery, in utero, or during the delivery—including congenital anomalies—should receive a "Y" indicator. Conditions that develop after birth should receive an "N." In other words, a coder should assign a "Y" for a baby born with polydactyly. However, a baby who develops respiratory distress three hours after delivery should receive an "N."

Hospital-acquired conditions

Hospital-acquired conditions (HAC) caused by medical errors are the leading cause of morbidity and mortality in the United States. Treating these conditions is also a financial burden, weighing in at an average of $5 billion annually. Medicare and other payers are recognizing that they should not pay additional money for preventable complications. Therefore, as of October 1, 2008, facilities have been receiving lower payments for certain HACs that occur in specific situations and are not POA. An HAC has

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payment implications only when it is the sole complication and comorbidity (CC) or major CC (MCC) and is not POA. When an additional condition is CC or MCC, it will still group to the higher-paying DRG. A condition is eligible to become an HAC if it:

- Is high cost and/or high volume
- Results in a higher-paying DRG when assigned as a secondary diagnosis
- Is reasonably preventable through evidence-based guidelines

The current list of HACs includes:

- **Foreign object retained after surgery.** Codes 998.4 (foreign body accidentally left during a procedure) and 998.7 (acute reaction to a foreign substance accidentally left during a procedure) denote this HAC. This doesn't include any objects surgeons intentionally leave in the patient after surgery, such as hardware to stabilize a fracture.
- **Air embolism.** Code 999.1 (air embolism to any site, following infusion, perfusion, or transfusion) denotes this HAC that refers to a condition in which air inadvertently passes through an open blood vessel, for example, when dry IV lines keep running and air enters the line of a subsequent IV and the air becomes embolic to the lungs. (***Note:*** There is an "excludes" note that pertains to childbirth.)
- **Blood incompatibility.** Code 999.6 (ABO incompatibility reaction) denotes this HAC, which only applies to ABO incompatibility and incompatible blood transfusion. It does not apply to Rhesus factor incompatibility (code 999.7); serum reactions (code 999.5) or other transfusion reactions (code 999.8x).
- **Stages III and IV (decubitus) pressure ulcers.** Code 707.23 indicates a stage III decubitus ulcer and code 707.24 indicates a stage IV decubitus ulcer. Note that CMS does not consider a condition an HAC when it is POA, but progresses during the hospitalization. The HAC payment provision is limited entirely to conditions that develop during the hospitalization. Therefore, an ulcer that progresses to stage III during an inpatient stay would not be considered an HAC.
- **Falls and trauma, including fractures, dislocations, intracranial injuries, crushing injuries, and burns.** The following codes denote this HAC when they are CCs or MCCs:
  - Codes 800–829: Fractures
  - Codes 830–839: Dislocations
  - Codes 850–854: Intracranial injuries
  - Codes 925–929: Crushing injuries
  - Codes 940–949: Burns
  - Codes 991–994: External causes (e.g., heat, air pressure, light, and frostbite)
- **Catheter-associated urinary tract infections (UTI).** Code 996.64 (infection due to indwelling urinary catheter) with a separate code to identify the specific infection denotes this HAC. Note that the catheter does not necessarily need to be indwelling for a patient to be at risk for a UTI that is POA.

- **Vascular catheter–associated infections (i.e., line sepsis).** Code 999.31 (infection due to central venous catheter—catheter-related bloodstream infection, not otherwise specified) denotes this HAC. The code includes infections due to peripherally inserted central catheters (i.e., PICC lines).
- **Mediastinitis after coronary artery bypass graft (CABG).** Code 519.2 (mediastinitis) and a CABG procedure code from the 36.10–36.19 range denote this HAC.
- **Surgical site infections following certain elective procedures, including certain orthopedic surgeries and bariatric surgery for obesity.** Related core measure guidelines for perioperative antibiotics and skin preparation have already been in place for years, so surgical site infections should raise a red flag. To denote a surgical site infection that occurs following an orthopedic procedure, such as a spinal fusion or shoulder arthroplasty, report a principal diagnosis code for the reason for the spinal fusion or shoulder arthroplasty (e.g., a back disorder or arthropathy) with a secondary code for the surgical site infection (code 996.67 or 998.59). For spinal fusions, report a procedure code from the 81.01–81.08 or 81.31–81.38 ranges. For shoulder/elbow arthroplasty, report a procedure code from the 81.23–81.24 range, 81.83, or 81.85. For a surgical site infection that occurs during bariatric surgery, report principal diagnosis code 278.01 with secondary diagnosis code 998.59 and procedure code 44.38, 44.39 or 44.95.
- **Certain manifestations of poor control of blood sugar levels, primarily diabetic hyperosmolarity, ketoacidosis, and hypoglycemia coma.** The HAC codes are those for coma, diabetic ketoacidosis, or hyperosmolarity identified by the following codes:
  - Codes 249.10, 249.11, 249.20, 249.21 for secondary diabetes mellitus
  - Codes 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23 for diabetes mellitus, Type 1 or Type II
  - Code 251.0 for hypoglycemic coma
- **Deep vein thrombosis (DVT) or pulmonary embolism following total knee replacement and hip replacement procedures.** Certain operative procedures have a higher incidence of development of DVT, particularly those that require that a patient's legs be in stirrups or on orthopedic procedures on the legs. Report this HAC with diagnosis codes 453.40–453.42 (for DVT) or 415.11 or 415.19 (for pulmonary embolism) with procedure codes for total hip or knee replacements (codes 81.54, 00.85–00.87, and 81.51–81.52).

CMS didn't propose any additional categories of HACs in the 2010 Inpatient Prospective Payment System (IPPS) proposed rule. However, CMS did propose adding two additional diagnoses into the falls and trauma series:

- Torus fracture of ulna (code 813.46)
- Torus fracture of radius/ulna (code 813.47)

Torus fractures (also known as buckle fractures) are conditions commonly suffered by children who fall on an outstretched hand. Both are CCs.

Surprisingly, CMS didn't mention additional exploration of adding ventilator-associated pneumonia (VAP) as an HAC. This may be because CMS is

continuing to gather data on the condition for which it assigned a specific code (ICD-9-CM code 997.31) as of October 1, 2008. This condition failed to meet the criteria of being reasonably preventable according to evidence-based guidelines.

In the fiscal year (FY) 2009 IPPS final rule, the majority of comments cited that VAP is only preventable in 40% of cases. This rendered VAP as ineligible by statutory requirements as being "reasonably preventable." Naysayers stated that the American Association of Respiratory Care's Evidence-Based Clinical Practice Guidelines is one example of an existing evidence-based standard designed to prevent VAP.

CMS has been working with the Centers for Disease Control and Prevention to closely monitor the evolving literature addressing the prevention of VAP through the application of evidence-based guidelines, but it has not yet come to a definitive conclusion.

Never events

As a part of CMS' continued emphasis on patient safety and to reduce the incidence of never events, CMS announced in January that it will no longer reimburse for services related to the following three preventable surgical errors:

- Wrong surgery or other invasive procedures performed on a patient
- Surgery or other invasive procedures performed on the wrong patient
- Surgery or other invasive procedures performed on the wrong site

Two new E-codes will be implemented for FY 2010 that will assist in identifying these circumstances:

E876.6	Performance of operation (procedure) on patient not scheduled for surgery
E876.7	Performance of correct operation (procedure) on wrong side/body part

Unlike an HAC, a never event prevents the hospital and physicians involved in the procedure from receiving any reimbursement.

Although this may seem similar to CMS' decision not to pay for HACs, and, in fact, both have the common goal of improving patient care and avoiding preventable medical errors, there are several important differences to note. For example, Medicare reimburses for services related to HACs—although the facility only receives a portion of typical reimbursement when the claim includes an "N" or "U" POA indicator. However, it will not reimburse for any aspect of a service related to the three wrong-site surgery never events mentioned above. In other words, unlike an HAC, a never event prevents the hospital and physicians involved in the procedure from receiving any reimbursement.

Case scenarios

Consider the following three case scenarios:

1. A patient is admitted with a severe pain in the left upper arm. The patient has a past history of lung carcinoma that was treated via chemotherapy

and surgical removal five years ago. The patient is discharged with a principal diagnosis of metastatic bone carcinoma to the left humerus. What is the appropriate POA indicator to assign?

Coders should report code 198.5 (secondary malignant neoplasm of bone and bone marrow) with a POA of "Y" because the neoplasm was clearly POA, even if the physician did not diagnose it until after the admission occurred.

2. A patient is admitted for a colon resection to treat colon carcinoma. Postoperatively on day three, the patient develops septicemia, which the physician treats with IV antibiotics. There was no evidence of septicemia prior to the admission. What is the appropriate POA indicator to assign?

Coders should report code 998.59 (other postoperative infection) and 038.9 (unspecified septicemia), with a POA of "N" because the condition was not POA, but developed postoperatively.

3. A patient is admitted to the hospital for acute exacerbation of congestive heart failure. On day four, the nurses' notes identify a stage III pressure ulcer on the patient's right hip. There was no mention in any of the information documented on the day of admission to identify the presence of this ulcer. What is the appropriate POA indicator to assign?

Coders should report code 707.23 (pressure ulcer stage III) with a POA of "U" unless the coder queries for the presence of this ulcer on admission. Note that the documentation of the site of the ulcer must come from the provider's documentation and that stage III and IV pressure ulcers are HACs—therefore, CMS will treat the "U" as an "N" for payment purposes. ■

Resources

- CMS *Present on Admission Indicator Reporting by Acute IPP,* December 2007
- CMS *Transmittal 289, CR 5679,* July 20, 2007
- *ICD-9-CM Official Guidelines for Coding and Reporting,* Effective October 1, 2007
- *MLN Matters Number: MM5499,* May 11, 2007
- *CMS Hospital-Acquired Conditions in Acute IPPS,* December 2007
- *CMS Benefit Policy Manual, Pub 100-02,* Chapter 15, §40.4
- FY 2009 Acute IPPS final rule
- FY 2010 Acute IPPS proposed rule